Agenda Item 3
6/20/07 Meeting

**Managed Risk Medical Insurance Board**
**May 16, 2007, Public Session**

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| Board Members Present: | Cliff Allenby, Areta Crowell, Ph.D., Sophia Chang, M.D., M.P.H., Richard Figueroa, M.B.A |
| Ex Officio Members Present: | Warren Barnes (on behalf of the Secretary for Business, Transportation and Housing), Bob Sands (on behalf of the Secretary for California Health and Human Services Agency), and Jack Campana |
| Staff Present: | Lesley Cummings, Denise Arend, Shelley Rouillard, Ruth Jacobs, Janette Lopez, Terresa Krum, Ronald Spingarn, Seth Brunner, Mary Anne Terranova, Ernesto Sanchez, Renee Mota-Jackson, Carolyn Tagupa, Ruben Mejia, Adrienne Thacker, Melissa Ng |

Chairman Allenby called the meeting to order.

## REVIEW AND APPROVAL OF MINUTES OF April 18, 2007 MEETING

The Board reviewed the minutes from the previous meeting. Dr. Crowell noted one correction concerning a duplicative word. Dr. Chang stated that she had already informed Ms. Thacker of a few other typos. A motion was made and unanimously passed to approve the minutes of the April 18, 2007 meeting as amended.

## HEALTH CARE REFORM UPDATE

Ronald Spingarn, Deputy Director of Legislation and External Affairs, provided an update on health care reform, noting that the Pro Tempore and Speaker's Offices recently released additional information about the financing for their bills.

## STATE LEGISLATION UPDATE

### Legislative Summary

Mary Anne Terranova, Legislative Coordinator, summarized a handout presented to the Board and public detailing pending legislation MRMIB staff is tracking.

**Assembly Bill 1 (Laird/Dymally)/Senate Bill 32 (Steinberg)**

Ms. Terranova summarized provisions of AB 1 and SB 32, which address children's health coverage. She noted that the sponsors, 100% Campaign and PICO, intend for the bills to be identical. Generally, the bills in their current versions would:

- Extend Medi-Cal and the Healthy Families program (HFP) income eligibility levels to children in families from 250% (existing) to 300% of the federal poverty level (FPL) regardless of immigration status
- Transition eligible children from coverage in existing local children's health initiatives into Medi-Cal or HFP;
- Allow families at or above 300% FPL to buy-in to HFP at full cost for children who have been without coverage for six or more months
- Establish a "bright line" at 133% FPL for income eligibility between Medi-Cal (for persons below 133% FPL) and HFP (for persons above 133% FPL), and;
- Make various changes to Medi-Cal and HFP application and enrollment processes.

Ms. Terranova then reviewed some areas of the bills in which MRMIB has concerns including:

<u>Buy-In Program</u>

- Would the provision excluding children who have coverage be sufficient to mitigate the adverse risk that will result from a buy-in program at full costs?
- Would families "buying in" be entitled to the premium discounts HFP provides for coverage in a CPP, pre-payment or payment via electronic method?
- Would dental, vision and/or California Children's Services benefits be included in coverage?

<u>HFP Application and Enrollment Processes</u>

- The bills would require submission of new applications for children enrolled in a CHI before transitioning to HFP. The transition is proposed to occur at the time of annual eligibility re-determination for each child. However, staff believe that new applications may not be needed and transitioning children at annual eligible re-determination may not be the most efficient or effective method to enroll children.
- The bills would require the Department of Healthcare Services (DHCS) and MRMIB to accept signatures on an application as actual verification of a family's income. However, under federal law, the state must verify income via electronic data bases and obtain written documentation when a data conflict exists.

- The bills would require MRMIB to conduct a full eligibility determination for Medi-Cal and other public programs. However, at present, HFP's single point of entry does not determine eligibility for all Medi-Cal program but rather reviews pursuant to requirements for the poverty programs. Doing a full determination (eg for any Medi-Cal eligibility category) would be cumbersome, substantially slowing down the enrollment process. It also is of questionable value given those children in a system of universal coverage.
- The bills would require use of technology to improve enrollment processes. However, this would likely require an extensive amount of work and would be extremely costly, and some provisions may not even be feasible.

Presumptive Eligibility (PE)

- The bills would require MRMIB and DHCS to monitor and track children in the same two PE programs. MRMIB would be required to follow up with DHCS regarding children in PE longer than two months. However, MRMIB has no jurisdiction over DHCS-administered programs and it is not clear what value MRMIB would add.
- The bills would require MRMIB and DHCS to collect and report the same specified information on a monthly and annual basis. These tracking and monitoring provisions would likely result in major costs.

Cliff Sarkin, Children's Defense Fund and the 100% Campaign, the bills' sponsors, said their intent in introducing the legislation is to provide a benchmark for larger health care reform efforts. He indicated that the sponsors have yet to meet with MRMIB to discuss the legislation and expressed confidence that once these discussions occur it will be possible to work out the issues.

Ms. Cummings thanked Mr. Sarkin for the sponsors' willingness to discuss MRMIB's concerns. She emphasized that staff's purpose in identifying MRMIB concerns was to begin the conversation.

**Introduction of Shelly Rouillard**

Chairman Allenby welcomed Shelley Rouillard, the new Deputy Director for Benefits and Quality Monitoring.

**AB 2 (Dymally)**

Ms. Cummings reminded the Board that last summer, PriceWaterhouseCoopers (PWC) provided MRMIB with cost estimates for a MRMIP program with no enrollment cap and no annual benefit cap. These estimates were produced in conjunction with legislation that would have provided additional financing for MRMIP through fees on health plans. Several months ago, MRMIB staff asked

PWC to update these estimates. She introduced Pete Davidson with PWC to present the updated analysis.

Pete Davidson, PWC, presented a five-year projection under different enrollment scenarios. He said that MRMIP enrollment has been lower than estimated last year, likely due to affordability issues. Thus nailing down what changes in enrollment might actually occur without an enrollment cap is somewhat difficult. The presentation also estimated the impact on premiums in the different market segments assuming that the costs would be paid by insurer fees.

Chairman Allenby asked for any comments. There were none.

**STATE BUDGET UPDATE**

Terresa Krum, Deputy Director for Administration, reported that the HFP budget was fully funded. She noted that the budget proposes to replace the HFP-to-Medi-Cal Bridge with presumptive eligibility because the federal government is no longer willing to provide FFP for the bridge. The Access for Infants and Mothers program was fully funded, and MRMIP funding remains at $40 million.

There was no discussion or public comment.

**FEDERAL BUDGET AND LEGISLATION**

**SCHIP Reauthorization**

Ronald Spingarn, Deputy Director of Legislation and External Affairs, explained the status of three bills pertaining to SCHIP reauthorization. He reviewed a side-by-side comparison of bills, prepared by the National Association of State Medicaid Directors. He expects the Senate to pass a bill in early/mid June, the House to pass one in July, and a bill to go to the President in early August.

He summarized provisions of the Rockefeller-Snowe bill:

- Provides $50 billion in funding above the current baseline of $25 billion for a total of $ 58.4 billion. Of the new funding, $33.4 billion is for SCHIP with the remainder for Medi-Cal
- Reduces from 3 to 2 years the amount of time states have to spend any given allotment
- Establishes a new funding formula that heavily weighs each state's historic spending levels, gives less weight to population data, and includes a geographic cost adjustment based on health care wage index. States' spending is reassessed every 2 years

    - Rockefeller's office issued numbers projecting allocations to all states funding; under these CA would get $1.27 billion for next fiscal year. compared with $1.1 billion

- Allows all states to enroll children up to 300% FPL, and those that meet certain conditions to go above 300% FPL
- Requires that dental services be provided
- Allows FFP for legal immigrants
- Establishes a 75% funding match for services related to language translation or interpretation
- Gives states flexibility in methods for determining citizenship in Medicaid.
- Allows states, at their option, to use express lane processes for enrollment of children
- Establishes a 2-year moratorium on Payment Error Rate Measurement (PERM") audits in SCHIP, to allowing the federal government time to address implementation problems raised by the states

Mr. Spingarn noted that Harbage Consulting is doing an analysis of funding formulas advanced in the different proposals. He will report his findings at the next Board meeting.

There were questions or comments.

**HEALTHY FAMILIES PROGRAM (HFP) UPDATE**

**Enrollment and Single Point of Entry Reports**

Ernesto Sanchez reported that January, February, March, and April saw the highest enrollment levels for HFP in the last nine years. He attributed this high enrollment level to the implementation of outreach programs and the streamlining of enrollment processes.

There were questions or comments.

**Administrative Vendor Performance Report**

Mr. Sanchez said the administrative vendor met all of its requirements for performance and quality at the single point of entry and for Healthy Families.

There were no further questions or comments.

**Enrollment Entities/Certified Application Assistants Reimbursement Report**

Larry Lucero presented a report on enrollment entities and certified application assistants' reimbursement.

There were questions or comments.

**February Advisory Panel Summary**

Mr. Campana reported on the February 6th meeting of the Healthy Families Advisory Panel. He expressed gratification that he was re-elected as Chair of the panel. After reviewing a number of areas for the panel to focus on in the year ahead, members decided to focus on barriers to enrollment and methods data to evaluate program effectiveness.

There were no questions or comments.

**PricewaterhouseCoopers Estimates on Cost of General Anesthesia**

Vallita Lewis, Special Projects Manager reported to the Board on whether data from Medi-Cal would be helpful in assessing the need for general anesthesia to be provided in the dentist's office. She reported that it would be difficult to use Medi-Cal data because the way the data is coded does not differentiate between general anesthesia and other procedures. Also, it does not differentiate the location where the anesthesia is administered. Board members asked a number of questions to assess whether there were any conditions under which the data could be useful, concluding that there were none.

Pete Davidson from PricewaterhouseCoopers (PWC) presented his assessment of the fiscal impact of allowing general anesthesia to be provided in the dental office. He indicated that estimating the change in the demand for services is difficult since the demand for services at this point in time is not known and there is little data to do a projection. His analysis presumes that MRMIB would adopt regulations limiting the circumstances under which the benefit could be provided in the dental office. With that assumption, there would be a shift in costs from health plans to dental plans but little increase in costs.

Dr. Crowell said that MRMIB could address access problems with the Rural Health Demonstration Project (RHDP).

The Chair asked for public comment.

Greg Alterton, California Dental Association (CDA), said Denti-Cal will switch to CPT coding this fall and once the change occurs there will be more precise data. CDA supports allowing general anesthesia in dentist's offices. It believes that the expansion could have a positive affect on access for certain patients. It has no hard data but hears from dentists of decreasing availability of hospital time for dentists due to increasing demand for hospital services. The PWC estimate of minimal cost is overstated – it would be less than minimal because presently dentists have to pay fees to use hospital facilities. However, CDA is concerned about PWC's assumption that anesthesia costs would be a covered benefit under a dental plan, which he said, contradicts state law. The benefit must be in the health plan, but dentists allowed to bill for it. CDA is especially concerned about this issue because any policy that HFP adopts could be established as a model

followed in the commercial market. CDA hopes the Board will consider expanding the benefit and would work with staff to address any lingering questions.

Dr. Chang indicated that Mr. Alterton appeared to be introducing a new twist to the issue since dentists are not contracted providers under the medical plans. Mr. Alterton answered that CDA is not necessarily introducing the idea. He is simply stating that current statute allows for the use of general anesthesia for dental procedures, but it would have to be billed to the medical side.

Mr. Figueroa asked if the Insurance Code and Health and Safety Code only allows dental anesthesia for children under seven with certain circumstances. Ms. Lewis responded that unless a disability or other condition exists, it is limited to those under seven.

There were no further public comments.

**Rural Health Demonstration Project (RHDP) Solicitation**

Alba Quiroz-Garcia from the Benefits and Quality Monitoring Division presented the first draft of Rural Health Demonstration Project solicitation for the Board's review. The budget for 2007-08 includes $ 5.8 million for a new round of RHFP projects. In the solicitation, MRMIB requests that health plans proposed creative projects addressing geographic access problems, special population needs or both. Examples within these categories are increasing hours of operation, increasing numbers of available providers, provision of mental health, mobile health, telemedicine, health education, prevention/wellness or substance abuse services. Ms. Cummings pointed out that this list also includes ambulatory and surgery centers providing general anesthesia for pediatric dental procedures.

Dr. Crowell indicated that the project types included in the solicitation were responsive to the issues of quality and access that the Board has been focusing on. She suggested that staff encourage bidders to review MRMIB reports on access and utilization to identify areas of greatest need.

Ms. Quiroz-Garcia indicated that the final solicitation will be brought to the Board in June for approval. Proposals are due July 18, 2007 and staff will present funding recommendations at the September meeting.

There were no further questions or comments.

**Consumer Assessment of Health Plan Survey (CAHPS), Dental Consumer Assessment of Plans (DCAPS) and Adolescent Health Survey**

Marielle Weindorf, of DataStat, the survey research firm that has conducted the consumer satisfaction surveys for HFP, provided the Board with background on

the surveys. In 2006, DataStat conducted satisfaction surveys for HFP health and dental services and administered a new survey focused on young adult health care. She said MRMIB is on the cutting edge of survey research methods. Not many organizations have used the Young Adult Healthcare Survey (YAHCS) used by MRMIB administered but it was recently adopted by the National Quality Forum as a national standard. There is little benchmark data for the survey, given that it is so new. However, during the demonstration period, the survey was administered in four states, including California to Medicaid and SCHIP subscribers.

Dr. Crowell complimented the work done, noting that she has been working to get this type of quality data on adolescent health since her first involvement with the program.

Mary Watanabe, analyst with Benefits and Quality Monitoring Division, reported the highlights of the survey results. Health and dental satisfaction rates are consistent with results in 2003, the last year the two surveys were administered. Overall, subscribers have a high level of satisfaction with their health plans and health services, comparable to other SCHIP and Medicaid programs. However, one area in which scores continued to be lower than SCHIP and Medicaid is in getting care quickly. Dental survey scores continue to have lower satisfaction rates than health plans, and this is particularly true for dental maintenance organizations. California remains the only state doing a satisfaction survey for dental coverage, so good benchmark data is not available.

On the young adult survey, DataStat sought out teens' perspectives directly, rather than having parents respond on their behalf. The results indicated the extent to which teens receive care they need. Staff were creative in ways to get a good response rate, including administering the survey in the summer and allowing for response via a web-based survey. This latter approach was not used by a lot of the adolescent responders.

Mr. Figueroa asked if some of the web surveys were blocked by filters because of words in the survey. Ms. Weindorf indicated she would research that question.

Ms. Watanabe said the majority of teens in the program consider themselves in good health, see a doctor for regular care, do not seem to have a problem getting care when they need it, do not appear to have a problem communicating with their doctors, and found counseling by providers to be helpful. There were higher scores associated with counseling and screening measures related to diet, weight and exercise. However, there were low scores on preventive screening and counseling for risky behaviors, (including pregnancies, STDs, depression, mental health and relationships), and receiving care in a confidential and private setting.

Ms. Watanabe said that staff plans to use a new dental survey this year and a new health survey when it is available. Staff will work on a solicitation package for the survey vendor contract to begin July 2008, and will come to the Board for input on the goals and priorities for these surveys. One option is to alternate years in which they young adult survey is conducted with that in which CAHPS are conducted. This should allow for a larger sample size for the surveys. Staff is also considering adding questions to the CAHPS survey about chronic conditions.

Mr. Figueroa said that HFP enrollment distribution was heavily weighted toward the younger people and that retaining adolescents is an important issue for plans to address. Dr. Crowell agreed that retention of adolescents is critical, noting that a significant number of adolescent boys (25%) and girls (30%) do not consider themselves very healthy. She suggested staff look specifically at this group to see their experience.

Ms. Watanabe said that staff will be meeting with plans to discuss survey results.

Board members commented on a job well done.

**ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE**

**Enrollment Report**

Mr. Sanchez asked if there were any questions regarding the enrollment report presented to the Board and the public. There were none.

**Administrative Vendor Performance Report**

Mr. Sanchez asked if there were any questions regarding the administrative vendor report presented to the Board and the public. There were none.

**MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE**

**Enrollment Report**

Mr. Sanchez asked if there were any questions regarding the enrollment report. There were none.

**Administrative Vendor Performance Report**

Mr. Sanchez stated that the MRMIP administrative vendor missed its performance mark in “seconds to a live voice”. This month’s performance was at 82 percent and the contracted level is 85 percent. He indicated that the vendor has taken corrective action and is currently monitoring daily to adjust their schedules.

**2006 Open Enrollment Results**

Kathi Dobrinen presented the 2006 MRMIP Open Enrollment Report, noting that results were consistent with the 2005 report.

Mr. Figueroa asked about the postcard process used in open enrollment. Ms. Lopez said it was used only for Healthy Families. Mr. Figueroa asked if the postcard process would be used for MRMIP as well. Mr. Sanchez said that staff would first like to evaluate the results of the postcard process in HFP.

**Semiannual Enrollment Estimate**

Chairman Allenby noted that that this agenda item would be held over until the next board meeting.

There being no further business to come before the Board, the meeting was duly adjourned at 12:58 pm.